DIABETES EMERGENCY ACTION PLAN
LAKE LOCAL SCHOOL DISTRICT

Student's Name: _____ Date of Birth: _____

Grade: _____ Home Room Teacher: _____

Location of supplies: Blood glucose monitor _____ Insulin supplies _____
Snack foods _____

Blood Glucose Monitoring

Contact parent if blood glucose is less than _____ or greater than _____ .

Student can perform own blood glucose checks without supervision. ❑ Yes ❑ No

Times to check blood glucose *(check all that apply):*

- ☐ with symptoms of hypoglycemia – low blood sugar (shaky, sweaty, confused)
- ☐ with symptoms of hyperglycemia – high blood sugar (thirsty, frequent urination)
- ☐ before lunch, _____ (time)
- ☐ before/after exercise ❑ other, please specify _____

Usual symptoms of low blood sugar _____

****EMERGENCY** Low Blood Sugar – (Hypoglycemia) treatment** - *(check all that apply):*

- ☐ 2-4 glucose tablets
- ☐ 4 oz. of juice, _____ (type)
- ☐ glucose gel (using finger place between cheek and gum in mouth) ½ tube
- ☐ other, please specify _____
  _____

*****It is parent's responsibility to provide the school with low blood sugar treatment snacks to have available at all times!***

Usual symptoms of high blood sugar _____

High Blood Sugar – (Hyperglycemia) treatment _____

Insulin - *(check all that apply):*

- ☐ Student not taking insulin at school
- ☐ Student takes insulin at school
  - ☐ SC Insulin ❑ Insulin with snack ❑ Humulin R
  - ☐ Insulin via insulin pump ❑ Humalog ❑ Other *(type)*
  - ☐ Insulin with lunch ❑ Novolog _____
- ☐ Student may give own sc injections with supervision
- ☐ Student using an insulin pump and may give own boluses
- ☐ Give _____ units of Humalog/Novolog/Humulin R SQ if glucose is > _____ .
- ☐ Give insulin according to current scale for elevated blood glucose; confirm dose with parent.
- ☐ Student may determine correct dose of insulin.
- ☐ School to administer insulin.

Snacks - *(check all that apply):*

Please allow a _____ gram snack at _____ am Please allow a _____ gram snack at _____ pm
Please allow a _____ gram snack prior to gym class Please allow a _____ gram snack at _____

Instructions for when food is provided to the class, such as part of a class party or food sampling:

_____

Special instructions: _____

_____

_____ _____ _____
Physician's Signature (required) *Physician's Printed Name* *Date*

_____ _____
Physician's Address *Physician's Phone Number in case of emergency*

I authorize school personnel to implement this management and emergency plan as described above.

_____ _____ _____/_____/_____
Parent/Guardian Signature *Date* *Phone Numbers (Home/Work/Cell) in case of emergency*

THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR *Form AO_51 5/16*

File: JHCD-E
Attachment A

LAKE LOCAL SCHOOL DISTRICT

PRESCRIPTION Medication Request Form

Under provisions of the Ohio Revised Code, all public schools require the following information when children require administration of prescription drugs. Please complete the following information and return to the school.

Student Last Name	First	Middle
Student Address		

Building	School Year	Grade	Date of Birth

Name of Medication	Dosage/Administration Instructions
Administration of medication to BEGIN	Administration of medication to END
Significant side effect (adverse reactions) which should be reported to the physician:	
Special instructions for administration of the drug, include sterile conditions and storage:	

Physician's SIGNATURE	PRINT Physician's Name	Physician's EMERGENCY Phone Number

With full knowledge of any emergencies, dangers, and risks related to the administration of such medication by the Lake Local Schools employees, officers, or agents, we, the undersigned, hereby waive all claims which might arise from said administration of medication to said minor child. We hereby assume full responsibility for the administration of such medication to said minor child and the results thereof. We agree to indemnify and hold harmless Lake Local School District, Lake Local Board of Education, its members, offers, employees, and agents from any and all liability relative to the administration of such medication.

1. ***There must be <u>written</u> notification to the school if there is any change in the physician's medication order.***
2. ***Medication must be in the original container as dispensed by the physician or pharmacy.***
3. ***It is advised that the medication form and medication be brought to the school by the parent/guardian.***
4. ***The student must assume responsibility for presenting him or herself for the medication at the appropriate time.***
5. ***Parents hereby authorize school personnel to communicate with the pharmacist or physician to clarify order information and communicate student progress.***
6. ***It is the responsibility of the parent/guardian to retrieve any remaining medication at the end of the administration period (or school year). Any unclaimed medication will be disposed of prior to the next school year.***

_____ _____ _____/_____/_____

Parent/Guardian Signature | Date | Phone Numbers (Home/Work/Cell)